

6130

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabaret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>5 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabaret County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>W. F. ELBERT BEVERLY</u>				4. DATE OF DEATH <u>June 11, 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1915</u>		9. AGE (In years last birthday) <u>42 yrs.</u>		10. IF UNDER 1 YEAR <u>5</u> Months <u>5</u> Days <u>8</u> Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Md</u>	
13. FATHER'S NAME <u>William Beverly</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Bafford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Mrs Elizabeth Beverly - Durrings, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Occlusion</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>1955</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 11, 1957</u> , to <u>June 11, 1957</u> , that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6/12/57</u>							
ACTUAL SIGNATURE <u>Page Pratt</u> M.D.				PRINCE FREDERICK			
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nation's Maus. Cemetery Island Creek - Cabaret Co., Md</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>6-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BATHING ONE 10

12

BUREAU V. 31

JUN 14 1957

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06130

6131

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN TB <u>47 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAURICE</u> Middle <u>F</u> Last <u>BOWEN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/24/1899</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11c. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		11d. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
12. FATHER'S NAME <u>Benson Bowen</u>		13. MOTHER'S MAIDEN NAME <u>Esmeralda Joper</u>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		15. SOCIAL SECURITY NO. <u>725X</u>	
16. INFORMANT <u>Jennie Bowen - Huntingtown, Md.</u>		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>Arthritis of Spine</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>725X</u>			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
20. I certify that I attended the deceased from <u>June 9, 1957</u> to <u>June 10, 1957</u> , that I last saw the deceased alive on <u>June 9, 1957</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Jett</u>		ADDRESS (Street, city or town, state) <u>Prince Frederick Md</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE C. JETT</u>		DATE SIGNED <u>9/12/57</u>	
21a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		21b. DATE THEREOF <u>6-12-57</u>	
21c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown</u>		21d. LOCATION (City, town, or county) (State) <u>Huntingtown Md</u>	
22. FUNERAL DIRECTOR'S SIGNATURE <u>Wm H Hutchins</u>		ADDRESS <u>Cwings Md</u>	
23a. REC'D BY REGISTRAR <u>Trace L Hutchins</u>		23b. REGISTRAR'S SIGNATURE <u>Trace L Hutchins</u>	

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JUN 14 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6132

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06131

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Maurice S Brooks</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8</u>
9. AGE (in years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Herchia Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Ozella Sewell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen Holland, Prince Frederick</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular renal disease</u> <u>442X</u> DUE TO (b) <u>Cye</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Plum Point</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. F. Sewell</u>		ADDRESS <u>Prince Frederick</u>	
24a. REC'D BY REGISTRAR <u>H. W. Ward</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	
DATE <u>6-24-57</u>		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6133

CERTIFICATE OF DEATH

06132

Reg. Dist. No. 52

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eliza (LYDIA) Ann (OX)		4. DATE OF DEATH Month June Day 28 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1870
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 8 Days 28 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Benjamin Lyons		14. MOTHER'S MAIDEN NAME Eliza Jane Fowler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Roland H. Trott, Huntingtown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6/25/57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 444X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Roger J. Trott		ADDRESS (Street, city or town, state) Prince Frederick, Md.	
DATE SIGNED 6/28/57		DATE SIGNED 6/28/57	
PHYSICIAN'S NAME (Type) W. E. JETT		PRINCE FREDERICK, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1957	
22c. NAME OF CEMETERY OR CREMATORY Huntingtown Cemetery		22d. LOCATION (City, town, or county) (State) Huntingtown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. JETT		ADDRESS Owings, Maryland	
24a. REC'D BY REGISTRAR June 30/57		24b. REGISTRAR'S SIGNATURE Grace L. Hutchins	

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1,2 FilmG217 6-24-57 et
6134
CERTIFICATE OF DEATH

06133

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rose Haven				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rose Haven 02X02			
d. NAME OF HOSPITAL (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS Prince Frederick, Md.			
3. NAME OF DECEASED (Type or print) Anna Deale				4. DATE OF DEATH Month June Day 30 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 78	IF UNDER 24 HRS. Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		
13. FATHER'S NAME Robert Montgomery			14. MOTHER'S MAIDEN NAME Anna McClean				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Mar Day 4 Year 1957 Hour 2 o. m. 30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Mar., 1957 , to 3 June, 1957 , that I last saw the deceased alive on 2 June, 1957 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. J. Weems				DATE SIGNED Huntingtown, Md.			
PHYSICIAN'S NAME (Type) G. J. Weems, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-5-57		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee's Sons Co				24a. REC'D BY REGISTRAR 300-4 St N.E.		24b. REGISTRAR'S SIGNATURE Dr. Hugh Hardy	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 3

JUN 5 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6135

CERTIFICATE OF DEATH

06134

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chiliet</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chiliet</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 26, 1871</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipyard Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Cabot Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Johnson</u>				14. MOTHER'S MAIDEN NAME <u>American Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-12-9622</u>		17. INFORMANT <u>William F. Johnson - Chiliet, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> <u>190X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Melanoma left leg</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 23</u> , 19 <u>57</u> , to <u>June 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>57</u> , and that death occurred at <u>St. Leonard</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. de Villarreale</u>				ADDRESS (Street, city or town, state) <u>St. Leonard</u>			
PHYSICIAN'S NAME (Type) <u>R. de VILLARREALE</u>				DATE SIGNED <u>6/30/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chiliet - Cabot Co. - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Ward</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BALDWIN 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. PLACE OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CLERGYMAN	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE		19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF SUPERVISOR	
21. SIGNATURE OF ASSISTANT SUPERVISOR		22. SIGNATURE OF CLERK		23. SIGNATURE OF RECEPTIONIST		24. SIGNATURE OF TELEPHONE OPERATOR	
25. SIGNATURE OF MAIL ROOM		26. SIGNATURE OF RECORDS SECTION		27. SIGNATURE OF STATISTICS SECTION		28. SIGNATURE OF PUBLIC HEALTH SECTION	
29. SIGNATURE OF LABORATORY SECTION		30. SIGNATURE OF RADIOLOGY SECTION		31. SIGNATURE OF PATHOLOGY SECTION		32. SIGNATURE OF BACTERIOLOGY SECTION	
33. SIGNATURE OF VIROLOGY SECTION		34. SIGNATURE OF IMMUNOLOGY SECTION		35. SIGNATURE OF EPIDEMIOLOGY SECTION		36. SIGNATURE OF PREVENTIVE MEDICINE SECTION	
37. SIGNATURE OF COMMUNITY HEALTH SECTION		38. SIGNATURE OF SCHOOL HEALTH SECTION		39. SIGNATURE OF OCCUPATIONAL HEALTH SECTION		40. SIGNATURE OF MARITAL STATUS SECTION	
41. SIGNATURE OF DIVORCE SECTION		42. SIGNATURE OF WIDOW SECTION		43. SIGNATURE OF SINGLE SECTION		44. SIGNATURE OF MARRIED SECTION	
45. SIGNATURE OF SEPARATED SECTION		46. SIGNATURE OF DIVORCED SECTION		47. SIGNATURE OF WIDOWED SECTION		48. SIGNATURE OF SINGLE SECTION	
49. SIGNATURE OF MARRIED SECTION		50. SIGNATURE OF SEPARATED SECTION		51. SIGNATURE OF DIVORCED SECTION		52. SIGNATURE OF WIDOWED SECTION	
53. SIGNATURE OF SINGLE SECTION		54. SIGNATURE OF MARRIED SECTION		55. SIGNATURE OF SEPARATED SECTION		56. SIGNATURE OF DIVORCED SECTION	
57. SIGNATURE OF WIDOWED SECTION		58. SIGNATURE OF SINGLE SECTION		59. SIGNATURE OF MARRIED SECTION		60. SIGNATURE OF SEPARATED SECTION	
61. SIGNATURE OF DIVORCED SECTION		62. SIGNATURE OF WIDOWED SECTION		63. SIGNATURE OF SINGLE SECTION		64. SIGNATURE OF MARRIED SECTION	
65. SIGNATURE OF SEPARATED SECTION		66. SIGNATURE OF DIVORCED SECTION		67. SIGNATURE OF WIDOWED SECTION		68. SIGNATURE OF SINGLE SECTION	
69. SIGNATURE OF MARRIED SECTION		70. SIGNATURE OF SEPARATED SECTION		71. SIGNATURE OF DIVORCED SECTION		72. SIGNATURE OF WIDOWED SECTION	
73. SIGNATURE OF SINGLE SECTION		74. SIGNATURE OF MARRIED SECTION		75. SIGNATURE OF SEPARATED SECTION		76. SIGNATURE OF DIVORCED SECTION	
77. SIGNATURE OF WIDOWED SECTION		78. SIGNATURE OF SINGLE SECTION		79. SIGNATURE OF MARRIED SECTION		80. SIGNATURE OF SEPARATED SECTION	
81. SIGNATURE OF DIVORCED SECTION		82. SIGNATURE OF WIDOWED SECTION		83. SIGNATURE OF SINGLE SECTION		84. SIGNATURE OF MARRIED SECTION	
85. SIGNATURE OF SEPARATED SECTION		86. SIGNATURE OF DIVORCED SECTION		87. SIGNATURE OF WIDOWED SECTION		88. SIGNATURE OF SINGLE SECTION	
89. SIGNATURE OF MARRIED SECTION		90. SIGNATURE OF SEPARATED SECTION		91. SIGNATURE OF DIVORCED SECTION		92. SIGNATURE OF WIDOWED SECTION	
93. SIGNATURE OF SINGLE SECTION		94. SIGNATURE OF MARRIED SECTION		95. SIGNATURE OF SEPARATED SECTION		96. SIGNATURE OF DIVORCED SECTION	
97. SIGNATURE OF WIDOWED SECTION		98. SIGNATURE OF SINGLE SECTION		99. SIGNATURE OF MARRIED SECTION		100. SIGNATURE OF SEPARATED SECTION	

BUREAU V. 3

11 3 1957

RECEIVED

BUREAU V. S.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G217 7-1-57 et

CERTIFICATE OF DEATH

06136

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robinson</u>				4. DATE OF DEATH Month Day Year <u>June 24 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1934</u>	
9. AGE (In years last birthday) yrs. <u>23</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John Robinson</u>			
14. MOTHER'S MAIDEN NAME <u>Betty Dalrymple</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>MRS BETTY ROBINSON Huntingtown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malperforation</u> <u>759.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/24</u> , 19 <u>57</u> , to <u>6/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Private</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Cal., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Robinson - Huntingtown, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>6-25-57</u> 24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>			

2064223XV4

CERTIFICATE OF DEATH

21

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. S.

JUN 26 1957

RECEIVED

Private

John R. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6138

CERTIFICATE OF DEATH

06137

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>ST. Marys</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCE FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u> 18X2.2	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JENNIE</u> Middle <u>D.</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar Dean</u>		14. MOTHER'S MAIDEN NAME <u>Laura Dick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Louis Thompson - Hollywood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Renal disease</u> DUE TO <u>Diabetes</u> (c) <u>Diabetes</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>4 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ate breakfast and became unconscious</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>442X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 28</u> , 19 <u>57</u> , to <u>June 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>57</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hollywood Md</u> DATE SIGNED <u>6/3/57</u>			
ACTUAL SIGNATURE <u>H. W. Ward</u> M.D. <u>Quincy Md</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-5-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Hollywood Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Robinson - Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-5-57</u>	
24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>			

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 3

JUN 7 1957

RECEIVED

6139 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle R Last Weems				4. DATE OF DEATH Month 6 Day 15 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 23, 1874	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Brooke Bond			
14. MOTHER'S MAIDEN NAME Elizabeth Tongue				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. No				17. INFORMANT Mrs. Lilly Patten - Mutual, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure - 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of Stomach - Carcino - DUE TO (c) not on							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 15, 1957 , to June 15, 1957 , that I last saw the deceased alive on June 15, 1957 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. de Villarreal M.D.				ADDRESS (Street, city or town, state) St Leonard			
DATE SIGNED 6/16/57				PHYSICIAN'S NAME (Type) R. de VILLARREAL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 18, 1957			
22c. NAME OF CEMETERY OR CREMATORY Christ Church Cem. Port Republic - Calvert Co. - Md.				22d. LOCATION (City, town, or county) (State) ST. LEONARDS, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE G. B. Harkness & Son - Mutual, Ind.				24a. REC'D BY REGISTRAR DATE 6-17-57			
24b. REGISTRAR'S SIGNATURE N. W. Ward							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. M.

JUN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06139

6:40

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 16 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lower Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ollie H. Wells First Oliver Henry Wells Middle Last				4. DATE OF DEATH Month June Day 8 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1873		9. AGE (In years last birthday) yrs. 84	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter Wells McKee Wells				14. MOTHER'S MAIDEN NAME Margaret Stevens Sunderland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Jesse Wells, Huntingtown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X						INTERVAL BETWEEN ONSET AND DEATH 60 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/6 , 19 57 , to 6/8 , 19 57 , that I last saw the deceased alive on 6/8 , 19 57 , and that death occurred at 1 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Page C. Jett				ADDRESS (Street, city or town, state) DATE SIGNED Prince Frederick 6/8/57			
PHYSICIAN'S NAME (Type) PAGE C. JETT				PRINCE FREDERICK			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Lower Marlboro Cemetery		22d. LOCATION (City, town, or county) (State) Lower Marlboro Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Hutchins				ADDRESS Quincy Md		24a. REC'D BY REGISTRAR DATE 6/8/57	
				24b. REGISTRAR'S SIGNATURE Grace Hutchins			

JUN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6141

CERTIFICATE OF DEATH

Reg. Dist. No. 51

06140

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parran			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital				d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last boy Wills				4. DATE OF DEATH Month Day Year 6 17 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-1957		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME LeRoy Wills			14. MOTHER'S MAIDEN NAME Yvonne Mason				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Father Address Parran				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia & no development 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/16 , 19 57 , to 6/17 , 19 57 , that I last saw the deceased alive on 6/16 , 19 57 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE H. W. Ward M.D. O. W. Ward PHYSICIAN'S NAME (Type) Dr Hugh Ward							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bureau		22b. DATE THEREOF 6-17-57	22c. NAME OF CEMETERY OR CREMATORY Private		22d. LOCATION (City, town, or county) (State) Chaney Calvert Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Father- LeRoy Wills Parran Md.				24a. REC'D BY REGISTRAR DATE 6-17-57		24b. REGISTRAR'S SIGNATURE H. W. Ward	

2064266XVI

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND

to file

BUREAU V. S.

JUN 24 1957

RECEIVED